

Residential Habilitation

Definition: Residential habilitation services include the care, skills training and supervision provided to individuals in a non-institutional setting. The degree and type of care, supervision, skills training and support of individuals will be based on the plan and the individual's needs. Services include assistance with acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting. Payments for residential habilitation are not made for room and board, the cost of facility maintenance, upkeep and improvement, other than such costs for modifications or adaptations to a facility required to assure the health and safety of residents, or to meet the requirements of the applicable life safety code. Payment for residential habilitation does not include payments made, directly or indirectly, to members of the individual's immediate family. Payments will not be made for the routine care and supervision which would be expected to be provided by a family or group home provider, or for activities or supervision for which a payment is made by a source other than Medicaid. Provider-owned or -leased facilities where Residential Habilitation services are furnished must be compliant with the Americans with Disabilities Act. Participants who receive Residential Habilitation paid at the daily rate are not allowed to receive the Adult Companion service.

Please note that individuals receiving Residential Habilitation cannot receive Companion Services through the ID/RD Waiver unless they reside in a SLP I and receive Residential Habilitation services at an hourly rate. If an individual is assessed to need Companion Services while residing in a SLP I (and they also receive Residential habilitation), then Companion Services can be provided at times when Residential Habilitation is not being provided. For Residential Habilitation provided through a SLP I, one unit equals one hour of service.

Providers: Residential Habilitation must be provided in facilities that are licensed by SCDDSN or the SC Department of Health and Environmental Control (SCDHEC) and are classified as Community Training Homes I or II (CTH I or II), Supervised Living Programs II or III (SLP II or III), or Community Residential Care Facilities (CRCF) or in facilities operated by the approved provider which are classified as Supported Living Programs I (SLP I).

Arranging for and Authorizing Services:

Like all waiver services the need for Residential Habilitation must be established prior to planning for and authorizing the service. For Residential Habilitation, the justification must be two-fold. The need for the service as defined in the ID/RD Waiver must be documented and there must be justification that those needs cannot be met through the provision of waiver services in the person's own home/community in conjunction with natural supports (i.e., outside of a licensed setting).

The waiver participant's need for the service will be documented in his/her assessments, support plan, Case Management Service Notes and other pertinent documentation. The **Assessment of Need for Residential Habilitation (IDRD Form A-RH)** with appropriate supporting documents must justify the need for services to be provided outside of the person's current home and in a licensed setting.

For ID/RD Waiver participants seeking (i.e., not currently receiving) Residential Habilitation services through the ID/RD Waiver, the initial need for Residential Habilitation will be determined by SCDDSN District Office. The determination must be made prior to the addition of "Residential Habilitation" to the Support Plan of ID/RD Waiver participants. District Office staff will utilize the completed **Assessment of Need for Residential Habilitation (IDRD Form A-RH)** including any supporting documents, along with any available SC Annual Assessments, Support Plans and Case Management Service Notes completed for the participant.

If the Case Manager feels that residential habilitation is needed or if the family requests the service, the **Assessment of Need for Residential Habilitation (IDRD Form A-RH)** should be completed along with supporting documentation and sent to district office staff. **Upon receipt of a complete Assessment of Need for Residential Habilitation, appropriate and complete supporting documents, SC Annual Assessments, Support Plans and Case Management Service Notes, the District Office will have ten (10) business days to approve or deny Residential Habilitation.** If approved, “Residential Habilitation” may be added to the participant’s Support Plan and authorized to the chosen provider. If not approved, a **Notice of Denial of Service (ID/RD Form 16-A)** must be completed within two (2) working days of notification that the service is denied (See Chapter 9 of the waiver manual for more details on denial of services). The denied service must be indicated on the form along with the reason(s) and any supporting comments. The original **Notice of Denial of Services (ID/RD Form 16-A)** is sent to the participant/legal guardian along with the written reconsideration/appeals process. A copy of the Notice must be part of the participant’s file.

If the recipient already resides in a SCDDSN sponsored residential setting and is determined to need the care, skills training, and supervision described in the Residential Habilitation Services definition, then the recipient’s plan must clearly outline the habilitation services (i.e., care, supervision, skills training) to be provided along with the amount and frequency. Residential habilitation services do not include payment for room and board. For CTH I, CTH II, SLP II and CRCF, one unit of residential habilitation equals one calendar day. For SLP I, one unit equals one hour of service. Documentation of the provision of Residential Habilitation must be available to support the provision of the service. Documentation of service provision includes:

- Completed residential assessments;
- Completed residential plans;
- Completed Residential Log which indicates “present”;
- Data showing the implementation of skills training included in the participant’s Residential Plan;
- Data showing the implementation of the participant’s Behavior Support Plan;
- Data showing the implementation of supervision in accordance with the participant’s Supervision Plan;
- Data showing the provision of care provided to the participant, including:
 - Medication administration records when the person is incapable of administering his/her own medications and/or medical treatments;
 - Documentation of assistance with activities of daily living when the person is incapable of completing without assistance;
 - Documentation of assistance with instrumental activities of daily living when the participant is incapable of completing those activities without assistance;
 - Documentation of transportation to and assistance with the receipt of health care services based on each participant’s specific health needs, condition, and desires;
 - Documentation of assistance with community involvement when the person is incapable of completing without assistance;
 - Documentation of assistance with self-preservation when the participant is incapable of completing without assistance;
 - Documentation of assistance with exercising his/her rights when the participant is incapable of completing without assistance;
 - Documentation of and assistance with managing personal property when the participant is incapable of managing without assistance.

Prior to adding Residential Habilitation to the Waiver Tracking System, you must first ensure the service is included on the STS and the location is correct. If residential habilitation is not already on the STS you cannot add it to the Waiver Tracking System. Once you have ensured that the information is entered correctly onto the STS you may proceed with adding the service to the Waiver Tracking System (one unit equals one day of service except in an SLP I where one unit equals one hour of service). Once the request is approved, Residential Habilitation Services can be authorized using the **Authorization for Services (ID/RD Form A- 28)**. The **ID/RD Form A-28** authorizes the Residential habilitation provider to bill the Financial Manager for services rendered.

Please note that when computing the units for Residential habilitation, if you are aware that the individual goes home every other weekend, then you would not include 365 units of residential habilitation on the budget. You would make the necessary adjustment on the budget. However, the amount and frequency on the Support Plan and the authorization should be 365 days per year in case the person is present at the residence more than anticipated. The number of days per year should be adjusted in leap years.

Monitoring Services: You must monitor the effectiveness, frequency, duration, benefits, and usefulness of the service along with the recipient's/family's satisfaction with the service. Information gathered during monitoring may lead to a change in the service, such as an increase/decrease in units authorized, change of provider, change to a more appropriate service, etc. At a minimum, services must be monitored **at** the frequency specified in the DDSN Case Management Standards. However, it is recommended that monitoring occur at least monthly for the first two months of initial placement, whenever there is a change in location with the same provider or whenever there is a change of provider.

Monitoring of this service may occur during contact with the individual/family or the provider of service. It may also occur during review of written documentation such as daily documentation on objectives and/or formal professional assessments. Some items to consider during monitoring include:

- Is the individual satisfied with his/her current residence?
- Is the apartment/home clean (sanitary)?
- Is the apartment/home in good repair?
- How often does the individual go home?
- Are there health/safety issues?
- Is there contact with family? What is the frequency?
- Does the individual have friends outside of the residential program?
- What type of recreational activities does the person participate in?
- What types of recreational activities does the residential program offer?
- Does the individual feel comfortable interacting with staff?
- Are there any new needs regarding Residential habilitation?
- How does the individual handle his finances?
- How much spending money does the individual get?
- How does the residential program account for the individual's money?
- What are the opportunities for choice given to the individual?
- What type of care and skills training is the individual receiving? Is the individual satisfied with the care and skills training?
- Are the training areas identified consistent with the individual's overall life goals?
- Is the individual making progress in training areas identified? If not, are goals and objectives reviewed and amended as needed?
- What is the level of supervision required?

Reduction, Suspension or Termination of Services: If services are to be reduced, suspended or terminated, a written notice must be sent to the participant/representative including the details regarding the change(s) in service, the allowance for appeal, and a ten (10) calendar day waiting period (from the date that the reduction/suspension/termination form is completed and sent to the participant/legal guardian) before the reduction, suspension or termination of the waiver service(s) takes effect. See *Chapter 9* for specific details and procedures regarding written notification and the appeals process.

**S. C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
ID/RD WAIVER**

**AUTHORIZATION FOR RESIDENTIAL HABILITATION
TO BE BILLED TO FINANCIAL MANAGER**

TO: _____

You are hereby authorized to provide Residential Habilitation for:

Participant's Name: _____

Date of Birth: _____

Address: _____

Phone Number: _____

Medicaid # _____

Only the number of units rendered may be billed. Please note: This nullifies any previous authorization to this provider for this service.

Hourly

Authorized Total: ____ (one unit = 1 hour of service provided in an SLP I setting)

Daily

Authorized Total: ____ (one unit = 1 night – present at midnight – in a CTH I, CTH II, CRCF or SLP II)

Case Management Provider: _____ Case Manager Name: _____

Address: _____

Phone # _____

Remit Bill To: _____

Signature of Person Authorizing Services

Date

ASSESSMENT OF NEED FOR RESIDENTIAL HABILITATION

S. C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS

ID/RD WAIVER

Answer each question, giving detailed explanations, and provide documentation, when needed, to support the responses. Copies of SC Annual Assessments, Support Plans and Case Management Service Notes will be reviewed but copies need not be provided. This assessment must be completed with input from the waiver participant's current primary caregiver / family. Once completed, the Assessment must be signed by the waiver participant, his/her primary caregiver/family representative, and the person completing the assessment. **Each Question must be answered to be accepted.**

1. Describe where and with whom this person currently lives:

[Click here to enter text.](#)

2. Describe any other services/supports that have been tried, but have failed to meet this person's needs. Indicate when the services/ supports were tried and why the services/supports were ineffective:

[Click here to enter text.](#)

3. Indicate any services/ supports available to address this person's needs that have not been tried and indicate why they have not been tried.

[Click here to enter text.](#)

4. Indicate which of these situations / circumstances exists for this person. For each situation /circumstance noted to exist, provide a detailed explanation of the situation/circumstance and provide documentation to support the existence of the situation/circumstance.

This person:

- ☐ Has been recently abused / neglected / exploited by his/her primary caregiver.

Documentation Provided: [Click here to enter text.](#)

- ☐ Is/will be homeless (is being discharged from placement and is unable to independently or with family; has no family or friends with whom he/she may live; is living with their family but the family will not continue to provide housing.* A statement signed by the waiver participant's family/primary caregiver must be included which clearly indicates that the waiver participant will no longer be permitted to live in the residence or will not be permitted to return to the family's/caregiver's home and that the family is unwilling to continue to care for and support the waiver participant. If the waiver participant refuses to return to his/her home after being away, he/she should indicate such.

Documentation Provided: [Click here to enter text.](#)

- ☐ Has seriously injured self or others and continues to pose a threat to the health and safety of others. Examples of documentation include, police reports and/or medical records specifying the injuries caused or threats posed must be included.

Documentation Provided: [Click here to enter text.](#)

- ☐ Has recently lost a primary caregiver or is at imminent risk of losing a primary caregiver and no other caregiver is available. Examples of documentation include obituary / death notices or medical records for the primary caregiver.

Documentation Provided: [Click here to enter text.](#)

☐ Has a primary caregiver who is 80 years of age or older with diminished ability to provide care. The caregiver's diminished capacity is likely to continue indefinitely due to the caregiver's physical or mental status. Care is provided now, but it is clear that the need for another caregiver is imminent and no other caregiver is available. *Examples of documentation include proof of age of the caregiver and medical records demonstrating his/her diminished capacity.*

Documentation Provided: [Click here to enter text.](#)

5. If none of the situations/ circumstances from question # 4 exists, describe in detail why the person's current living arrangement cannot continue.

[Click here to enter text.](#)

As the person completing this assessment, I attest that the information contained in this document is true and accurate.

Signature

Date

Printed Name, Title

I, _____, as the primary caregiver / family representative of this waiver participant, attest that I have been given the opportunity to have input into the creation of this document, I have read it and I agree with the information it contains.

Signature

Date

Relationship to Waiver Participant

Participant Signature _____

Date: _____